Complete Summary

GUIDELINE TITLE

2002 national guidelines on the management of adult victims of sexual assault.

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guidelines on the management of adult victims of sexual assault. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [19 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Sexually transmitted infections and/or pregnancy following sexual assault
- Psychological sequelae of sexual assault

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Screening
Treatment

CLINICAL SPECIALTY

Infectious Diseases
Obstetrics and Gynecology
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To present a national guideline for the management of sexually transmitted infections and pregnancy prevention in adult victims of sexual assault and to address the need for psychological support in this group of patients

TARGET POPULATION

Adult female victims of sexual assault in the United Kingdom

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation/Diagnosis

1. History taking
2. Physical examination
    - Genital inspection and noting or diagramming injuries
    - Colposcopic examination and photography
    - Inspection of the throat for petechial haemorrhages on the palate (if history of forced oral penetration)
    - Anal examination including proctoscopy (if recent history of forced anal penetration)
3. Laboratory investigation at initial examination
    - Cultures for Neisseria gonorrhoeae and tests (e.g., nuclear acid amplification) for Chlamydia trachomatis from any sites of penetration or attempted penetration.
    - Vaginal slides for microscopy for yeasts, bacterial vaginosis, and Trichomonas vaginalis. Culture for Trichomonas vaginalis.
    - Blood for syphilis serology, hepatitis B, human immunodeficiency virus (HIV) testing and, if indicated, hepatitis C.

Management/Treatment

1. Handling the victim's case (such as, reporting to the police, and identification of laboratory specimens as having medico-legal) implications
2. Antibiotic prophylaxis to cover chlamydia and gonorrhea
    - Ciprofloxacin and doxycycline
    - Ciprofloxacin and azithromycin
    - In pregnant or breast feeding women, amoxycillin plus probenecid and erythromycin
3. Hepatitis B vaccination
4. HIV prophylaxis using post-exposure prophylaxis guidelines for occupational exposure
5. Pregnancy prevention
    - Post-coital oral contraception-levonorgestrel (Yuzpe method considered, but not preferred)
    - Intrauterine contraceptive device insertion

6. Counselling support
7. Treatment of regular sexual partners, as appropriate
8. Follow-up
    - Repeat sexually transmitted infections screening and serological testing for syphilis, hepatitis B, HIV, and hepatitis C where indicated.
    - Review emotional support needs of patient and referral for counselling or psychological assessment, as appropriate

MAJOR OUTCOMES CONSIDERED

Identification of gonorrhoea, chlamydia, or trichomonas infections in adult victims of sexual assault

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developers searched Medline (U.S. National Library of Medicine) for the years 1980-September 2000 using "rape" as an exploded Medical Subject Heading (MeSH), limited to "adult" and limited to "English language" combined with exploded subject headings "HIV infection", "sexually transmitted diseases", and "patient care management".

The guideline developers also searched the Cochrane Library – issue 4 2000 using a free text search with the expression "sexual and assault" as well as an exploded MeSH heading search for the concept "rape".

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence:

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

II a

- Evidence obtained from at least one well designed controlled study without randomisation

II b

- Evidence obtained from at least one other type of well designed quasi-experimental study

III

- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The revision process commenced with authors being invited to modify and update their 1999 guidelines. These revised versions were posted on the website for a 3 month period and comments invited. The Clinical Effectiveness Group and the authors concerned considered all suggestions and agreed on any modifications to be made.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grading of Recommendations:

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The initial versions of the guidelines were sent for review to the following:

- Clinical Effectiveness Group (CEG) members
- Chairs of UK Regional GU Medicine Audit Committees who had responded to an invitation to comment on them
- Chair of the Genitourinary Nurses Association (GUNA)
- President of the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD)
- Clinical Effectiveness Committee of the Faculty of Family Planning and Reproductive Health Care (FFP).

Comments were relayed to the authors and attempts made to reach a consensus on points of contention with ultimate editorial control resting with the Clinical Effectiveness Group. Finally, all the guidelines were ratified by the councils of the two parent societies.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the levels of evidence (I-IV)and grades of recommendation (A-C) are repeated at the end of the Major Recommendations field.

Management

Service availability and staffing

- Need to maintain training in communication skills amongst all staff groups
- If identified as sexual assault victim - give suitable appointment-minimum waiting - if possible out of clinic hours.
- Experienced doctor - patient offered choice of female or male where possible

Reporting to the police (level of evidence IV, grade of recommendation C)

- Ensure local Police aware of clinic service.
- Has patient reported to police - do they want to? Forensic examination useful up to 7 days post assault - must be prior to any medical examination.
- If a patient does not wish to report, the examination should be conducted and the findings documented with the thought in mind that occasionally the Doctor may be asked to produce a medical report at a later date.
- The orifices used in the assault, the timing of the assault, prior and subsequent consenting sexual intercourse, use of condoms by the assailant, and whether or not ejaculation had occurred should be documented.
- Signed consent is essential if any information is subsequently disclosed to the police. This should be with the understanding that the Court may order disclosure of all information divulged during the consultation.

History taking

- Unrushed and sensitive manner.
- Orifices involved in the assault should be clarified - many women will not disclose forced oral or anal penetration without direct questioning.
- The sexual history both before and after the assault.
- Past medical history, gynaecological, menstrual and contraceptive history.

Examination (IV, C)

Injuries requiring immediate attention will take precedence over any other examination.

- If the assault is recent, accurately document injuries found on genital inspection (diagrams may be useful). Petechial haemorrhages on the palate should be sought with a history of forced oral penetration. Anal examination including proctoscopy should be performed if there is a recent history of forced anal penetration, noting any trauma.
- Colposcopic examination and photography rarely provides any useful information outside a full forensic examination and may produce unnecessary distress (Estreich, Forster, & Robinson, 1990; Bowyer & Dalton, 1997).

Investigations (III, B)

A full sexually transmitted infections screen at presentation is recommended as research suggests a significant incidence of pre-existing sexually transmitted infections among women who allege rape and a smaller yet significant incidence

of acquisition of sexually transmitted infections resulting from the rape. There is also a high rate of default with second and subsequent appointments (Jenny et al., 1990; Rambow et al., 1992).

Initial examination should include the following:

- Cultures for Neisseria gonorrhoeae and tests for Chlamydia trachomatis from any sites of penetration or attempted penetration. Gram stained slides of urethral, cervical, and rectal specimens for microscopy for gonococci. (Although C trachomatis culture is the only test currently accepted in court, many laboratories no longer provide culture and the sensitivity of this test is suboptimal. Nucleic acid amplification tests (NAAT) offer much greater sensitivity but their medico-legal use has not been established. It is advisable to take two endocervical swabs; one for nucleic acid amplification testing and another for culture which should be placed immediately in chlamydia transport medium. The advantage of this duplication is that, in the event of a negative culture but positive first nucleic acid amplification test, the residual specimen can be used for a confirmatory test by a second nucleic acid amplification test which uses a different amplification target from the first. [IV, C] (A.J. Herring, PhD, Head, PHLS Genitourinary Infections Reference Laboratory)).
- Vaginal slides for microscopy for yeasts, bacterial vaginosis, and Trichomonas vaginalis. Ideally, if available, culture for Trichomonas vaginalis.
- Blood for syphilis serology and serum save. (Hepatitis B, HIV and, if indicated, hepatitis C testing should be offered, as the patient may have a pre-existing risk for infection. If testing is not indicated, the sample should be saved to clarify the timing of any subsequent seroconversion).
- It is advisable that specimens are identified as having potential (albeit unlikely) medico-legal implications so the laboratory can complete a full range of confirmatory tests. The "chain of evidence" required for forensic specimens to be admissible as evidence (essentially every handover of the specimen is signed, dated, and timed) is often difficult to implement in a hospital laboratory situation (IV, C).

Treatment

Antibiotic prophylaxis

In situations where the patient may default, is unable to tolerate the distress of a repeat examination, or requires an intrauterine contraceptive device for emergency contraception then prophylactic treatment that would cover both chlamydia and gonorrhea may be offered.

Recommended regimens (IV,C) (UK National Guidelines- Clinical Effectiveness Group)

(The efficacy of these regimens in preventing gonorrhea or chlamydial infection after sexual assault has not been studied.)

- Ciprofloxacin 500 mg immediately (stat), doxycycline 100 mg twice daily (BD) for 7 days

or

- Ciprofloxacin 500 mg immediately and azithromycin 1 g immediately.

Pregnancy or breast feeding

Amoxycillin 3 g immediately plus probenecid 1 g immediately and erythromycin 500 mg twice daily for 14 days.

The efficacy of antibiotic regimes in preventing gonorrhoea or chlamydia infections after sexual assault has not been studied (Centers for Disease Control and Prevention (CDC), 1998a).

Many patients prefer prophylactic therapy to repeat examination (Ledray, 1993). They should be advised to abstain from sexual intercourse until treatment has been completed.

Hepatitis B vaccination (IV, C)

Should be offered to all victims of sexual assault; however, it is not known for how long after the assault it may still be efficacious. As hepatitis B has a long incubation period it may be of value up to 3 weeks after the event (Crowe et al., 1996). It can be given as an accelerated course at 0, 1, and 2 months or as a 0, 1, and 6 month regime (PHLS Hepatitis subcommittee CDR review, 1992) with the last dose coinciding with final serological testing.

HIV prophylaxis (IV, C)

Post exposure prophylaxis after sexual exposure is a controversial area and no widely accepted recommendations exist (Laurie, Kennedy, & Rutherford, 2000).

A discussion about HIV infection should form part of the initial interview with the patient even if she/he has not raised the subject, as this is often a concern. Although HIV seroconversion has followed sexual assault the risk of HIV acquisition from heterosexual sexual assault in the United Kingdom is low.

An individual risk assessment will inform any decision about the offer of post-exposure prophylaxis. This involves several factors, including the background prevalence of HIV in the area where the assault occurred, any knowledge of the risk behaviour of the assailant, stranger rape versus known assailant, presence of other sexually transmitted infections and the type of assault (e.g. forced anal penetration, being a greater risk than penile-vaginal rape by an HIV infected assailant). If post-exposure prophylaxis is to be given then it is recommended that this should be started no later than 72 hours after a high risk exposure, the regime being in line with the post exposure prophylaxis guidelines for occupational exposure. (HIV Post-Exposure Prophylaxis, 2000) The patient needs to be aware of the unproven efficacy and potential toxicity of the treatment.

Pregnancy prevention

If there is risk of pregnancy, post-coital oral contraception can be issued if within 72 hours of the assault and no risk of pre-existing pregnancy (levonorgestrel 0.75mg 12 hourly x 2 doses is preferred to the Yuzpe method) (Cheng et al., 2000). (Ia, A)

Intrauterine contraceptive device insertion if used as post-coital contraception would be best covered by prophylactic antibiotics (as above) in these circumstances.

Counselling

- Post traumatic stress disorder is common following sexual assault, however there is no evidence that brief psychological debriefing reduces this. (Foa, 1997; Wessely, Rose, & Bisson, 2000) The Health Adviser/ nurse counsellor can discuss the patient's need for optional emotional support.
- Links with the local victim support organisation, rape crisis groups and a local Psychologist should be present to facilitate referral, if needed.
- As psychological sequelae may develop months or years later, communication with the general practitioner to ensure continuity of care should be encouraged.

Sexual partners

Arrangements need to be made to see and treat the regular sexual partners of patients found to have a sexually transmitted infections, if they may be infected. Patients and partners should abstain from sexual intercourse until treatment is completed.

Follow up (see Table 1)

If prophylaxis was not given after the initial examination then a repeat sexually transmitted infections screen at 2 weeks after the assault is advisable and should detect infections acquired at the time of the assault that were not detected on the initial examination (IV, C) (CDC, 1998a). This is also an ideal time to review the emotional support needs of the patient.

Serological tests for syphilis, hepatitis B, and HIV should be offered (with counselling) at 12 weeks and, in high risk cases, 24 weeks, as seroconversions of hepatitis B and HIV have occasionally been documented outside the 12-week period (Crowe et al., 1996; CDC, 1998b) (IV, C). Although the risk from sexual assault is likely to be very low, Hepatitis C can be transmitted sexually and testing can be offered, particularly if the assailant is high risk (e.g. intravenous drug use history) at 3 and 6 months.

Table 1. Timing of investigations

Tests

Chlamydia -- at presentation (recommended timing); at 2 weeks post-assault if prophylaxis not given after first screen

Gonorrhoea -- at presentation (recommended timing); at 2 weeks post-assault if prophylaxis not given after first screen

Trichomonas vaginalis/Bacterial vaginitis -- at presentation (recommended timing); at 2 weeks post-assault if prophylaxis not given after first screen

Syphilis -- at 3 months post-assault (recommended timing); at 1 month post-presentation if history or circumstances indicate

Serum save -- at presentation (recommended timing)

Human immunodeficiency virus/Hepatitis B -- at 3 months post-assault (recommended timing); at presentation and at 6 months post-assault if history or circumstances indicate

Hepatitis C antibody -- at presentation and at 3 months and 6 months post-assault only if history or circumstances indicate

Treatment

Post-coital contraception -- at presentation only if history or circumstances indicate

Antibiotic prophylaxis -- at presentation only if history or circumstances indicate

Hepatitis B vaccine -- at presentation, at 1 month post-presentation and 3 months post-assault (all recommended timings)

Counsellor review -- at presentation and at 2 weeks post-assault (recommended timing); at 1 month post-presentation, 3 months-post assault, and 6 months post-assault if history or circumstances indicate

Definitions

The following rating scheme was used for major management recommendations.

Levels of Evidence

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one other type of well designed quasi-experimental study

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- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

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B (Evidence levels IIa, IIb, III)

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C (Evidence level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is graded and identified for select recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate evaluation and screening, and effective management of sexually transmitted infections in adult female victims of sexual assault

POTENTIAL HARMS

If post-exposure human immunodeficiency virus (HIV) prophylaxis is to be given the patient needs to be aware of the unproven efficacy and potential toxicity of the treatment.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These recommendations are limited to the management of victims of sexual assault within a genitourinary clinic setting and include screening for and treatment of sexually transmitted infections and addressing the need for psychological support. The documentation of a forensic examination and the collecting of specimens for evidential purposes are beyond the scope of these recommendations and should not be attempted by a physician untrained in forensic medicine. The recommendations relate to female victims of sexual assault but the principles are the same in the management of male victims of sexual assault
- These guidelines must be interpreted with a degree of flexibility dependent on the assessment of the emotional and physical state of the patient as well as the risk of infection. A pragmatic and compassionate approach is needed for a patient who may be desperately trying to regain control after the assault. The benefit to the patient of any investigation must be weighed against the risk of exacerbating or prolonging the patient's distress.
- The efficacy of antibiotic regimes in preventing gonorrhoea or chlamydia infections after sexual assault has not been studied.
- Post exposure human immunodeficiency virus (HIV) prophylaxis after sexual exposure is a controversial area and no widely accepted recommendations exist.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The Clinical Effectiveness Group reminds the reader that guidelines in themselves are of no use unless they are implemented systematically. The following auditable outcome measures are provided:

- Sexually transmitted infections screen performed at initial visit. Target 90%.
- Offer of emergency contraception if applicable. Target 90%.
- Offer of emotional support made at initial visit. Target 90%.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guidelines on the management of adult victims of sexual assault. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [19 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Aug (revised 2002)

GUIDELINE DEVELOPER(S)

British Association of Sexual Health and HIV - Medical Specialty Society

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Clinical Effectiveness Group (CEG)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Author: Helen Lacey

Clinical Effectiveness Group (CEG) Members: Keith Radcliffe (Chairman); Imtyaz Ahmed-Jushuf; Jan Welch; Mark FitzGerald; Janet Wilson

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Conflict of Interest: None

GUIDELINE STATUS

This is the current release of the guideline. This guideline updates a previously released version.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available in HTML format from the Association for Genitourinary Medicine (AGUM) Web site. Also available in Portable Document Format (PDF) from the Medical Society for the Study of Venereal Diseases (MSSVD) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- UK national guidelines on sexually transmitted infections and closely related conditions. Introduction. Sex Transm Infect 1999 Aug;75(Suppl 1):S2-3.

Electronic copies: Available in Portable Document Format (PDF) from the Medical Society for the Study of Venereal Diseases (MSSVD) Web site.

The following is also available:

- Revised UK national guidelines on sexually transmitted infections and closely related conditions 2002. Sex Transm Infect 2002;78:81-2

Print copies: For further information, please contact the journal publisher, BMJ Publishing Group.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 8, 2000. The information was verified by the guideline developer on January 12, 2001. This summary was updated on August 5, 2002.

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